assess how the LEV in Plastic Surgery has changed from 2003 to 2013, compared with five other specialties.
Methods: Articles in 2003 and 2013 of the top three general plastic surgery journals (by 2013 Impact Factor-IF) were systematically labeled as LEV 1–5, defined by the American Society of Plastic Surgeons. Comparisons were made with five other surgical specialties.
Results: The mean LEV for plastic surgery improved by 4.1% from 3.86 to 3.70 in 2003 to 2013. Journals representing all six specialties included in this study have improved their mean LEV (range 3.7%–10.9%). Plastic Surgery ranks 5/6 of specialties in order of the mean LEV achieved in both 2003 and 2013. All specialties reduced the proportion of level five evidence published. There was a slight trend towards higher LEV with higher weighted or mean IF but this did not reach significance (p=0.065 and 0.079 respectively).
Conclusion: Plastic Surgery is tending towards higher levels of evidence albeit at a slow pace. The specialty must continue to drive towards higher LEV to improve the corpora of research for evidence-based decision-making.

0824: THE NEED FOR CORE OUTCOME REPORTING IN AUTOLOGOUS FAT GRAFTING FOR BREAST RECONSTRUCTION

G. Wellstead[2,*], R. Agha[3], A. Fowler[2], T. Pidgeon[4], D. Orgill[5]. The Academic Surgical Collaborative[1]. [1] *The Academic Surgical Collaborative, UK;* [2] *Barts and The London School of Medicine and Dentistry, UK;* [3] *Mid-Yorkshire Hospitals NHS Trust, UK;* [4] *University Hospital Coventry and Warwickshire NHS Trust, UK;* [5] *Brigham and Women's Hospital Boston, USA*

Aim: There is growing interest in the potential of autologous fat grafting (AFG) for breast reconstruction. This follow-on work from our recent systematic review of this area looks at the range of outcomes used, their definition and whether there is a need for a core outcome set to aid reporting.
Methods: Following on from prior work involving a search of 20 databases from 1986 to March 2014, 35 studies meeting the inclusion criteria for our systematic review were assessed.
Results: A total of 51 different outcomes were reported across the 35 studies. Each study reported a median of 5 separate outcomes (range 2–14), of which a median of 3 outcomes was defined (range 0–14). A median of 2 outcomes per paper were pre-specified in the methods (range 0–12), with a median of only 2 outcomes both defined and pre-specified (range 0–12). The most commonly reported outcome, reported by 26 studies, was “Operative details”, however 8 different definitions were used. Overall, there was a poor proportion of defined and pre-specified outcomes, employing a wide range of different definitions.
Conclusion: There is a need for a core outcomes set for AFG to minimise outcome and reporting bias and aid evidence synthesis.

Posters: Coloproctolgy

0023L: THE CORRELATION OF SURGEONS' AGE TO POST-OPERATIVE MORTALITY

R. Edmonds[a,*], D. Nepogodiev[b], T. Pinkney[b]. [a] *King's College London, UK;* [b] *University of Birmingham, UK*

Aim: This study aimed to identify whether surgeon’s age is related to colorectal cancer mortality rates.
Methods: Mortality rates for surgeons who performed >10 elective resections for bowel cancer in 2010–2012 were extracted from data published by the Association of Coloproctology of Great Britain and Ireland. Surgeons' ages were estimated based on year of graduation, extracted from the General Medical Council register. Surgeons were split in to three age groups for analysis (≤42, 43–49 and ≥50 years).
Results: Outcomes were available for 25,827 procedures performed by 615 surgeons. Overall pooled unadjusted mortality was 2.9% (745/25827). For surgeons aged ≤42 years it was 2.27% (from 225 surgeons), it was 3.16% (n = 192) for ages 43–49 years, and 3.28% (n = 127) for those ≥50 years. Surgeons aged ≤42 had significantly lower rates versus both surgeons aged 43–49 (odds ratio (OR) 1.39, p < 0.001) and ≥50 (OR 1.45, p < 0.001). There were no significant differences between surgeons aged 42–49 and ≥50 years. Analysis of adjusted mortality rates replicated these findings.
Conclusion: Surgeons aged ≤42 years have lower post-operative colorectal cancer mortality rates than surgeons aged >42 years. However, risk-adjustment may have been incomplete and senior surgeons may undertake more complex and high-risk procedures.

0145: THE YIELD OF PATHOLOGY FROM DIAGNOSTIC FLEXIBLE SIGMOIDOSCOPY IN PATIENTS UNDER 40 YEARS

P. Orchard[*], R. Mustafa, C. Thorn, R. Alexander. *Great Western Hospital, UK*

Aim: Flexible sigmoidoscopy (FS) allows both macroscopic and histological assessment of the left colon and rectum. Current guidelines define the need for FS in patients over 40 yrs, but is lacking in those under 40yrs.
Methods: Data was analysed from our prospectively collected database over a one-year period (April 2013–14). Patients undergoing diagnostic FS under 40ys were included (n = 136). Fisher's exact and Chi squared were used for analysis.
Results: 38 patients (28%) yielded pathology; 29 (21%) had a colitis, 5 (4%) had polyps, and 4 patients had other benign pathology. No patients had a cancer. Analysis of indication for FS indicated a non-significant (p = 0.09) propensity of finding pathology in patients with rectal bleeding and abdo pain or change of bowel habit (46%).
Our data supports a smaller published series (Mittapalli et al 2008) for pathology yield (p = 0.33).
Conclusion: This study provides evidence that FS in the under 40's identifies pathology in approximately 1 in 4 patients. Presenting with a PR bleed in addition to other symptoms is, perhaps more likely to yield pathology.

0161: WHAT HAPPENS TO PILONIDAL ABSCESSES AFTER EMERGENCY INCISION AND DRAINAGE?

A.O. Rae[*], M.J. Lee, A. Harikrishnan. *Northern General Hospital, UK*

Aim: Pilonidal abscess is a common condition, which is managed by the on-call team. It is recognised that some patients will recur after incision and drainage (I&D) and will require further treatment. Our aim was to identify what proportion of patients undergoing I&D required subsequent intervention, with the aim of informing our follow-up policy.
Methods: Patients undergoing I&D of pilonidal abscess over a four-year period were identified through theatre registers. Dates of procedures, intervals between procedures and follow-up data were recorded.
Results: I&D was performed 311 times over four years. Median duration of follow-up was 679 days. The risk of recurrence after first I&D was 10.9%, increasing to 20.5%, 42.9%and 66.6% after the 2nd, 3rd and 4th events respectively. Median time to recurrence was 163, 165, 127 and 39 days for 1st, 2nd, 3rd and 4th episode respectively. After the first recurrence, 65% of patients were followed-up. One patient was offered follow-up after third recurrence and none of those with a 4th recurrence had follow-up.
Conclusion: 90% of patients had index drainage only. The risk of recurrence increases with each episode of abscess requiring a drainage procedure and the associated interval decreases. We should follow-up patients after their first recurrence.

0184: AUDIT TO ASSESS EFFECTIVE REPORTING AND IMPROVE EARLY DETECTION OF SURGICAL SITE INFECTIONS IN COLORECTAL SURGERY AT A DISTRICT GENERAL HOSPITAL

A. Lai[*], C. Thorn, S. Moseley, J. Gorham, F. Gooding, N. Earl. *Great Western Hospital, UK*

Aim: Surgical site infections (SSIs) affect patient morbidity and have significant financial implications through extended hospital stay. Accurate reporting of SSI is essential for surveillance and early detection of SSIs allows timely intervention. Our aim was to assess effectiveness of